Public Health
Seattle & King County

*For public health use only-----***State case number:**_____ **Lab number:**_____

ARBOVIRAL ENCEPHALITIS/MENINGITIS CASE REPORT FORM

Case Identifying Information:

Last Name_____ First Name_____ Middle Initial ___

Date of Birth: _____/_____/_____ Gender: ☐Male ☐Female ☐Unknown

Race: ☐White ☐Black ☐Asian/PI ☐Am Indian ☐Other ☐Unknown Ethnicity: ☐Hispanic ☐Nonhispanic ☐Unknown

Street/RFD Address_____Apt. #_____

County_____City/State/ZIP _____

Telephone: home (_____) _____ Occupation _____ work# (_____) _____

Clinical Information:

Date of onset: _____/_____/_____ Current diagnosis: ☐Encephalitis ☐Meningitis ☐Febrile illness with acute onset

☐Other diagnosis (specify)_____

Hospitalized? ☐Yes ☐No ☐Unknown If yes, name of hospital:_____

Date of admission: _____/_____/_____ Date of discharge: _____/_____/_____

Outcome: ☐Alive ☐Dead ☐Unknown If patient died, date of death: _____/_____/_____

Primary clinician caring for patient/telephone #_____

Symptoms

Fever ≥100F or 38C	☐Yes	☐No	☐Unknown	Change in mental status	☐Yes	☐No	☐Unknown
Headache	☐Yes	☐No	☐Unknown	Stiff neck/meningeal signs	☐Yes	☐No	☐Unknown
Weakness	☐Yes	☐No	☐Unknown	Rash	☐Yes	☐No	☐Unknown
Gastrointestinal symptoms	☐Yes	☐No	☐Unknown	Seizures	☐Yes	☐No	☐Unknown
Myalgias	☐Yes	☐No	☐Unknown	Cranial nerve abnormalities	☐Yes	☐No	☐Unknown
Tremors	☐Yes	☐No	☐Unknown	Ataxia, extrapyramidal signs	☐Yes	☐No	☐Unknown

Acute flaccid paralysis ☐Yes ☐No ☐Unknown | If yes, public health completes acute flaccid paralysis form.

Other signs/symptoms (specify)_____

Arthropod exposure (3-14 days before onset) ☐Yes ☐No ☐Unknown Specify_____

Travel history (3-14 days before onset) ☐Yes ☐No ☐Unknown If Yes, where?_____

Recent immunization (esp. yellow fever, JE) ☐Yes ☐No ☐Unknown If Yes, when?_____/_____/_____Type:_____

Received organ transplant or blood product within 30 days of onset ☐Yes ☐No ☐Unknown If Yes, specify_____

Donated tissue/organ/blood product within 7 days of onset ☐Yes ☐No ☐Unknown If Yes, specify

Pregnant ☐Yes ☐No ☐Unknown If yes, due date _____/_____/_____

Breastfeeding ☐Yes ☐No ☐Unknown If yes, birth date of infant _____/_____/_____

Laboratory & Radiology Results

CSF obtained? ☐Yes Date: ___/____/___ ☐No ☐Unknown MRI/CT scan of head ☐Yes Date: ___/_____/___ ☐No ☐Unknown

CSF profile: WBCs % lymphs___ % neutrophils_____ RBCs_____ Glucose_____ Protein_____

Peripheral WBC _____ % lymphs % neutrophils_____% bands_____

Test results:

WNV: Serology IgM_____Date: ____/_____/_____ IgG_____ Date: ____/_____/_____ Name of lab:_____

CSF IgM_____Date: ____/_____/_____ IgG_____ Date: ____/_____/_____ Name of lab:_____

Enterovirus: ☐Yes ☐No ☐Unknown Specimen: _____coll. date____/____/_____ Result_____Lab _____

HSV: ☐Yes ☐No ☐Unknown Specimen:_____ coll. date____/____/_____ Result_____Lab

Other: _____

Person or agency reporting: _____ Report date:

Address: _____ Telephone/pager:

Return to: *Public Health – Seattle & King County, Communicable Disease Epidemiology and Immunization Section, FAX: 206.296-4803 or mail: 999 3rd Ave, Suite 900, Seattle, WA 98104 For more information, call 206.296.4774 *Rev 8/29/2003*